tures for acid-fast bacilli are consistently negative for the final 6 months. Despite the high incidence of patients with preexisting liver disease within the noncooperative group, adverse liver reactions due to isoniazid, rifampin, and pyrazinamide are remarkably infrequent.

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Exposure of Expectant Mothers to Cytomegalovirus Infections

HUMAN CYTOMEGALOVIRUS (CMV) infections are common worldwide. The epidemiology of this virus has not been completely delineated but it is known that transmission from person to person requires intimate contact. Among adults, the primary route of transmission is by intimate (oral or sexual) contact. Most cytomegalovirus infections are asymptomatic or mild.

Infection with cytomegalovirus has particular significance for pregnant women. The virus can infect the fetus in utero following a primary infection in the mother and, unlike rubella, also by reactivation of latent maternal cytomegalovirus. The risk of manifest congenital disease at birth appears to be largely associated with a mother's first (or primary) infection during pregnancy but the relative contribution to fetal damage by reactivated maternal cytomegalovirus infections has yet to be defined. In the United States 0.5% to 2.2% of all newborns are congenitally infected as shown by viral excretion at birth but most of these infected infants show no clinical signs of impairment at delivery. About 10% of these infections (about 1 per 1,000 births) result in some overt congenital cytomegalovirus disease at birth, but some of the asymptomatic congenital infections may produce effects detectable only later in life.

The results of several studies suggest that from 3% to 28% of all pregnant women in the US shed cytomegalovirus from their cervix by the third trimester of pregnancy. The virus has also been detected in the breast milk of 13% of women with cytomegalovirus antibodies. Such viral shedding is thought to be due predominantly to the reactivation of latent infection during pregnancy. Infants born to mothers shedding this virus may be infected connatally—that is, during labor or at birth—or postnatally. Most connatal and postnatal infections, like those acquired in utero, are asymptomatic, but some of these infections may conceivably produce subtle effects, the long-term results of which have not been well documented. Studies in the US also indicate that up to 30% of all children acquire cytomegalovirus infections by 3 years of age. Avoiding or reducing the risk of exposure to cytomegalovirus is difficult because of the large number of asymptomatic virus shedders in the general population.

Whether women who provide care to any group of infants and children have a greater risk of acquiring a primary infection with this virus than women not so employed has not been established. The most important routes of cytomegalovirus transmission from children to adults are apparently via contact with urine or saliva of virus shedders, for example, through kissing or poor personal hygiene after handling soiled diapers. Thus, nursery and other child care staff who are in contact with known infected infants and who adhere to routine patient care practices such as handwashing should not be at increased risk of acquiring a cytomegalovirus infection.

Women of childbearing age should be informed that this virus is ubiquitous and that prevention of infection from infants and children in any setting (home or occupation) is best accomplished by observing good personal hygiene. These women should also be advised that this virus is of relatively low infectivity, and, in contrast to the transmission of rubella and rubeola infection, intimate contact is usually required to transmit it. Antibody testing programs for women who are routinely in close contact with children cannot be recommended at the present time, since there is no information to indicate (or suggest) that such a program would reduce the risk of congenital damage to infants infected with cytomegalovirus.

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Office Treatment of Alcoholism

MOST PHYSICIANS have been trained in public hospitals to recognize alcoholism by a patient's end-stage liver disease or other serious sequelae of heavy drinking. Patients who are obviously alcoholic represent only 5% or so of those who will go on to die an average of ten years prematurely because of their alcohol-related problems.

The average alcoholic person is a blue-collar or white-collar worker or a homemaker who drinks too heavily on evenings or weekends or experiences short periods each year when alcohol problems escalate. In these persons, who compose 15% to 20% of the patients seen in practice, cirrhosis rarely develops (seen in only 15% of alcoholic persons), and they are unlikely to enter a physician's office in an intoxicated state. The fall of blood alcohol concentrations to zero on an almost daily basis results in a moderate to mild withdrawal syndrome that, for 95% of these persons, causes tremor, anxiety and a flulike feeling.

Recognition of this average middle-class alcoholic person is important to clinicians because such patients are not likely to respond in a predictable way to therapeutic intervention if they continue drinking. Patients usually have nonspecific complaints, perhaps request a physical examination, and are likely to have mild hy-